Service Information

Provider Networks

To provide and manage care for its members, each Care Management Organization (CMO) develops a network of providers under contract with or employed by the CMO. As the sole payment source for Family Care services, CMOs provide their own service authorizations.

Before providing services included in the Family Care benefit package to Family Care members, providers should contact the CMO to make arrangements. Refer to Appendix 1 of this guide for a list of CMO telephone numbers.

Providers should continue to bill Medicaid fee-for-service for Medicaid services that are not included in the Family Care benefit package when provided to Medicaid-eligible CMO members.

Member Requests for Providers Not Affiliated With a Care Management Organization

Providers who have not contracted with a CMO may, under certain circumstances, obtain CMO authorization to provide services to CMO members. For instance, a member may request a specific provider for services, or the CMO may not have a specialist in its network to meet a member's specific needs.

Care Management Organizations are required to consider member requests for providers outside the network, but the requested provider must meet the quality standards and accept the rate of pay set by the CMOs. Care Management Organizations are not required to add providers requested by members to their networks.

Care Management Organizations may not reimburse providers at rates higher than the Medicaid rate for Medicaid services included in the Family Care benefit package.

Covered Services

Medicaid Services Included in the Family Care Benefit Package

Refer to Appendix 4 of this guide for a list of Medicaid-covered services included in the Family Care benefit package.

In general, long term care services (for example, home health services) are included in the Family Care benefit package. Acute and primary care services, including physician and hospital, and medications, are not included in the Family Care benefit package and will remain fee-for-service for those who are Medicaid eligible.

Home and Community-Based Waiver Services Included in the Family Care Benefit Package

The Family Care benefit package also includes services covered by the Community Options Program and the home and community-based waivers program.

Services Not Included in the Family Care Benefit Package

Refer to Appendix 4 of this guide for a list of Medicaid services that are not included in the Family Care benefit package.

Providers should continue to bill Medicaid fee-for-service for Medicaid services that are not included in the Family Care benefit package when provided to Medicaid-eligible CMO members.

For members who are not eligible for Medicaid, providers should bill members or the members' commercial health insurance for any services that are not included in the Family Care benefit package.

Provision of Noncovered Services

The CMO is responsible for authorizing the Medicaid-covered services included in the Family Care benefit package that the member requires to meet his or her long term care needs. These services are listed in the member's Individual Service Plan. However, the CMO is not restricted to providing only the services listed in the benefit package and may determine that alternative or non-traditional services can cost-effectively meet a member's needs. Therefore, providers should always contact the CMO before assuming the member will need to pay for a service that is not included in the Family Care benefit package, not covered by Medicaid, and not covered by the member's commercial health insurance.

A member may file a complaint or grievance if the CMO refuses to provide a service included in the Family Care benefit package that the member believes would help meet his or her long term care needs.

Members may receive and pay for services that are not covered by either Family Care or Medicaid, but:

- Providers should contact the CMO to determine if the CMO would authorize the service as part of the member's Individual Service Plan.
- Providers should contact the CMO to determine if the CMO has refused to provide the service and if the member is grieving the refusal. If the outcome of the grievance is favorable to the member, the CMO is required to pay for the service.
- If the CMO does not authorize the service, and the member does not grieve the CMO's decision to not authorize the service, the provider:
  1. Should contact the CMO to verify all policies and procedures for accepting payment from Family Care members for services.
  2. Is required to inform the member prior to providing the service that the CMO will not reimburse the service.
  3. Is required to tell the member prior to providing the service that he or she will be billed for the service.
  4. Is encouraged to obtain a written statement in advance verifying that the recipient has accepted liability for the service.

Note: Refer to the Covered and Noncovered Services section of the All-Provider Handbook for information on providing noncovered Medicaid services to Medicaid-eligible members.

Emergency and Urgent Care Services

Emergency Care

Emergency medical services may be needed in situations such as:

- Trouble breathing.
- Broken bones.
- Suspected poisoning.
- Suspected heart attack.
- Choking.

Members are instructed to dial 911 in the event of a medical emergency.

Emergency medical services are typically provided by physicians, emergency rooms, or emergency medical technicians/ambulances and are not included in the Family Care benefit package. Therefore, providers of emergency medical services need not be in the CMO provider network.

However, providers should consult the appropriate CMO prior to providing any follow-up services that are included in the Family Care benefit package.

Providers should always contact the CMO before assuming the member will need to pay for a service that is not included in the Family Care benefit package, not covered by Medicaid, and not covered by the member's commercial health insurance.

Urgent Care

In an urgent care situation, the member requires care sooner than a routine care appointment allows.

Urgent care situations involving Family Care services may occur in such situations as:

- A member is discharged from the emergency room and requires transportation to return home.
- A member visits the emergency room and is not admitted, but requires a home health aide immediately.
- A member's home health aide is sick and the member requires an immediate replacement.

Providers are required to seek authorization for any urgent care services included in the Family Care benefit package (such as home health or durable medical equipment) from the CMO prior to providing the services.

For urgent care services that are *not* included in the Family Care benefit package, Medicaid-eligible members are instructed to go to the Medicaid-certified clinic of their choice; members who are not eligible for Medicaid may go to any clinic of their choice.

24-Hour Access to the Care Management Organization

Each CMO has a telephone number available 24 hours a day, seven days a week. Providers and members may use the number for urgent situations and to request authorization for services included in the Family Care benefit package. The CMO is required to respond to calls within 30 minutes.

Refer to Appendix 1 of this guide for a list of the CMOs' 24-hour telephone numbers.

Each CMO has a telephone number available 24 hours a day, seven days a week.

Out-of-Area Care

Members traveling outside of their CMO service area sometimes require routine care. As with providers located in the service area, providers outside of the service area are required to have CMO authorization prior to providing services in the Family Care benefit package.

Prior to providing services, providers should contact the appropriate CMO at the number indicated by the Eligibility Verification System or listed in Appendix 1 of this guide.

The CMO may refuse to reimburse for services if the provider does not obtain CMO authorization prior to providing the services.

Prior Authorization

Existing Medicaid Fee-for-Service Prior Authorization

Existing Medicaid fee-for-service prior authorization (PA) for services included in the Family Care benefit package will not be applicable when a member enrolls in Family Care. Providers are required to obtain a new service authorization from the CMO to provide services included in the Family Care benefit package.

However, providers should not discard a member's Medicaid PA once that member enrolls in a CMO because:

- If a member disenrolls from a CMO, but remains eligible for Medicaid under fee-for-service, the services provided that are within the grant and expiration dates would still be allowable under the original PA.
- The PA may apply to several procedures, including Medicaid services that are not included in the Family Care benefit package. In this instance, providers can still use the authorized PA to bill their approved fee-for-service services to Medicaid.

Care Management Organization Authorization

For services included in the Family Care benefit package, service authorization decisions are made at the local level by the CMO and

not through the Medicaid PA process. The CMO is responsible for authorizing the services included in the Family Care benefit package.

All providers, including providers who are not affiliated with a CMO, should contact the CMO prior to providing any of the services included in the Family Care benefit package since the CMO:

- Is the sole payment source for Family Care services received by its members.
- May refuse payment for services it did not authorize.

The CMO is responsible for authorizing the services included in the Family Care benefit package.